AB133. 164. The DATA protocol: developing an educational tool to improve note-writing in hospitals

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Background: There are many benefits of a well-written clinical note. National guidelines exist which mandate the inclusion of several basic details in every note. From this perspective, the current study aimed to assess quality of surgical inpatient notes, the level of intern training in this area, and to explore interventions which may be of benefit.
Methods: Healthcare records were assessed before and after an intervention which comprised of a teaching session and memory cues utilising the mnemonic DATA (Date and time, Addressograph, Team, Author details). A survey was also distributed to 124 interns to assess the level of training they had received in this area. Comparative analyses of quantitative data were performed using chi-squared test for categorical variables.
Results: A total of 200 notes were included for analysis. Those written after the intervention were significantly more likely ($P<0.01$) to contain patient details (95% *vs.* 45%), time seen (71% *vs.* 17%), author name (84% *vs.* 43%), job title (81% *vs.* 47%), bleep number (64% *vs.* 34%), and registration number (79% *vs.* 58%). Of 45 respondents to the survey, 82.2% had not received training on how to write a clinical note. Most (91.1%) had not been made aware of national guidelines for record-keeping and 66.7% had simply copied the format of notes from the preceding team. Almost two-thirds did not feel adequately trained in this area.
Conclusions: This study provides support for dedicated teaching on note-writing in hospitals, this should ideally be carried out prior to doctors commencing internship, however it would likely be effective at any stage of training.
Keywords: Medical education; record-keeping; surgery

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